OMB No. 0920-0212: Approval Expires 01/31/2000

Notice – All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to other persons or used for any other purpose. Public reporting burden of this collection of information is estimated to average 4 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to DHHS Reports Clearance Officer; Paperwork Reduction Project (0920-0212); Room 531-H, Hubert H. Humphrey Building, 200 Independence Avenue, SW; Washington, DC 20201.

FORM **HDS-1**
(5-12-99)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

MEDICAL ABSTRACT – NATIONAL HOSPITAL DISCHARGE SURVEY

A. PATIENT IDENTIFICATION

1. Hospital number . . . . . ☐☐☐☐

2. HDS number . . . . . ☐☐☐☐

3. Medical record number _____

4. Date of admission . . . . . Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

5. Date of discharge . . . . . Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

6. Residence ZIP Code . . . . ☐☐☐☐☐

B. PATIENT CHARACTERISTICS

7. Date of birth — Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

8. Age *(Complete only if date of birth not given)* . . . . . Units ☐☐☐ 1 ☐ Years 2 ☐ Months 3 ☐ Days

9. Sex *(Mark (X) one)*
1 ☐ Male 2 ☐ Female 3 ☐ Not stated

10. Race
1 ☐ White
2 ☐ Black
3 ☐ American Indian/Eskimo/Aleut
4 ☐ Asian/Pacific Islander
5 ☐ Other *(Specify)* _____
6 ☐ Not stated

11. Ethnicity *(Mark (X) one)*
1 ☐ Hispanic origin 2 ☐ Non-Hispanic 3 ☐ Not stated

12. Marital status *(Mark (X) one)*
1 ☐ Married 3 ☐ Widowed 5 ☐ Separated
2 ☐ Single 4 ☐ Divorced 6 ☐ Not stated

13. Expected source(s) of payment

	Principal *(Mark one only)*	Other additional sources *(Mark all that apply)*
1. Worker's compensation	☐	☐
2. Medicare	☐	☐
3. Medicaid	☐	☐
4. Other government payments	☐	☐
5. Blue Cross/Blue Shield	☐	☐
6. HMO/PPO	☐	☐
7. Other private or commercial insurance	☐	☐
8. Self pay	☐	☐
9. No charge	☐	☐
10. Other *(Specify)* _____	☐	☐

☐ **No source of payment indicated**

14. Status/Disposition of patient *(Mark (X) appropriate box(es))*

Status
1 ☐ Alive → Disposition
a. ☐ Routine discharge/discharged home
b. ☐ Left against medical advice
c. ☐ Discharged, transferred to another short-term hospital
d. ☐ Discharged, transferred to long-term care institution
e. ☐ Other disposition/not stated
2 ☐ Died
3 ☐ Status not stated

(Over)

Figure I. Medical abstract for the National Hospital Discharge Survey, 1997

C. FINAL DIAGNOSES (including E-code diagnoses) (ICD-9-CM codes may be entered if no narrative is available)

Principal: _____

Other/additional: _____

D. SURGICAL AND DIAGNOSTIC PROCEDURES (ICD-9-CM codes may be entered if no narrative is available)

	Date of procedure(s)							
	Month		Day		Year			
Principal:								
Other/additional:								

☐ NONE

Completed by	Date

*U.S.GPO:1999-750-126/00039

Figure I. Medical abstract for the National Hospital Discharge Survey, 1997—Con.